This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Benefit Description at **www.bcbsks.com/blueaccess** or by calling **1-800-332-0307**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** person / **$300** family. Doesn't apply to preventive services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your Benefit Description to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out of pocket limit on my expenses?	Yes. Medical Network**: $3,650** Ind/ **$7,300** Family. Non Network: **$4,150** person/**$8,800** family. Pharmacy **$2,750** Ind/**$5,500** Family	The **out of pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out of pocket limit?	Premiums, balance-billed charges, pharmacy coinsurance, and health care this plan doesn't doesn't cover.	Even though you pay these expenses, they don't count toward the **out of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.bcbsks.com** or call **1.800.332.0307.**	If you use a Network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your Network doctor or hospital may use a Non Network **provider** for some services. Plans use the term Network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your Benefit Description for additional information about **excluded services**.

Questions: Call **1-800-332-0307** or visit us at **www.bcbsks.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-800-332-0307** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a Non Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a Non Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions (All services must be medically necessary and appropriate)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 child*/$20 adult copay/visit	Deductible then 50% coinsurance.	*18 and under
	Specialist visit	$25 child*/$40 adult copay/visit	Deductible then 50% coinsurance.	*18 and under
	Other practitioner office visit	Copay is applicable to the provider type	Deductible then 50% coinsurance.	Manipulation therapies limited to 30 visits per year.
	Preventive care/screening/immunization	$0. Preventive is without cost share.	Not Covered	Colonoscopies, Mammograms and Pap Smears-Not limited to once per year/in network 100% regardless of diagnosis.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 35% coinsurance	Deductible then 50% coinsurance.	Lab services paid at 100% when using Quest or Stormont -Vail.
	Imaging (CT/PET scans, MRIs)	Deductible then 35% coinsurance	Deductible then 50% coinsurance.	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions (All services must be medically necessary and appropriate)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	20% co-insurance (retail and mail order)	20% co-insurance (retail and mail order) of the plan's allowed charge.	First fill is a 30 day supply at retail or mail. A 60 day supply is allowed at retail or mail for all subsequent fills. **Diabetic and Asthma Generic Medication:** 10% co-insurance with a $10 maximum per 30 day supply. **Generic Contraceptives:** subject to 0% member coinsurance.
	Preferred brand drugs	35% co-insurance (retail and mail order)	35% co-insurance (retail and mail order) of the plan's allowed charge.	First fill is a 30 day supply at retail or mail. A 60 day supply is allowed at retail or mail for all subsequent fills. **Diabetic and Asthma Preferred Medication:** 20% co-insurance with a $20 maximum per 30 day supply. **Preferred Contraceptives:** subject to 0% member coinsurance.
	Non-preferred brand drugs	60% co-insurance (retail and mail order)	60% co-insurance (retail and mail order) of the plan's allowed charge.	First fill is a 30 day supply at retail or mail. A 60 day supply is allowed at retail or mail for all subsequent fills. **Diabetic and Asthma Non Preferred Medication:** Subject to 60% member coinsurance. **Non Preferred Contraceptives**: Subject to 60% member coinsurance

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions (All services must be medically necessary and appropriate)
	Specialty drugs	25% co-insurance (with $75 maximum) per 30 day supply.	Not Covered	First fill allowed at retail. All subsequent fills must be filled through CVS Caremark Specialty (1-800-237-2767).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 35% coinsurance	Deductible then 50% coinsurance	
	Physician/surgeon fees	Deductible then 35% coinsurance	Deductible then 50% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay, deductible then 35% coinsurance	$100 copay, deductible then 35% coinsurance	Must meet emergency criteria. Copay waived if admitted with 24 hours.
	Emergency medical transportation	Deductible then 35% coinsurance	Deductible then 35% coinsurance	Must meet emergency criteria.
	Urgent care	$50 copay/visit	Deductible then 50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization is required.
	Physician/surgeon fee	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health/Substance use disorder outpatient services	$10 child/$20 adult copay per visit, other outpatient deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization is required for inpatient service. For help call New Directions: 1-800-952-5906.
	Mental/Behavioral health/Substance use disorder inpatient services	Deductible then 35% coinsurance	Deductible then 50% coinsurance	
If you are pregnant	Prenatal and postnatal care, Delivery and all inpatient services	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization required for stays longer than 48/96 hours.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions (All services must be medically necessary and appropriate)
If you need help recovering or have other special health needs	Home health care	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization may be required.
	Rehabilitation services	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization is required.
	Habilitation services	Not Covered	Not Covered	Unless under Autism rider of the policy.
	Skilled nursing care	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization is required.
	Durable medical equipment	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization required.
	Hospice service	Deductible then 35% coinsurance	Deductible then 50% coinsurance	Prior Authorization may be required. Inpatient Hospice care limited to 6 months.
If you or your child needs dental or eye care	Eye exam	$0 for first annual visit, then $25 child*/$40 adult copay per visit	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Benefit Description for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Private Duty Nursing
- Hearing Aids

Other Covered Services (This isn't a complete list. Check your Benefit Description for other covered services and your costs for these services.)

- Nutritional Evaluation and Diabetes Management
- Bariatric Surgery (for qualified patients)
- Hearing Exam to determine hearing loss and newborn screening
- Most coverage provided outside the United States

  See www.bcbsks.com/already-a-member/coverage-home-and-away.html

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact COBRAGuard at 1-866-952-6272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for coveraed services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Chinese:	此“保险金与覆盖范围概要”有中文版本，请致电	1-800-432-3990
Spanish:	Este Resumen de Beneficios y Cobertura està disponible en español, por favor llame al	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,640
- **Patient pays** $2,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$2,500
*Limits or exclusions	$200
Total	**$2,900**

***Recommended care for this example included over the counter medications which are excluded.**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,060
- **Patient pays** $1,340

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$300
Coinsurance	$900
*Limits or exclusions	$40
Total	**$1,340**

***Recommended care for this example included over the counter medications which are excluded.**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from Network **providers**. If the patient had received care from Non Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.